Integrative Health Care

Dr. Susan Janssens BSc, ND

ONLINE

Comprehensive Patient Questionaire

Part A - General Information & History

Last Name: First Name: Initials: Age:

Street Address: DOB: / / (dd mm yy)

City: Province: Postal Code:

Home: ( ) Bus. ( ) Mobile: ( )

Email:

Marital Status: O Single O Married O Divorced O Common Law

First Name of Partner/Significant Other:

Children: O Y O N Ages & Sex:

Occupation: Place of Employment:

Emergency Contact: Phone: ( )

REFERRAL: O Self O Physician O Other:

Physician: Phone: ( )

Dentist: Phone: ( )

AHC #:

List any health professionals you currently see:		**Reason**
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	

Maya Health Centre
#2, 1922 - 9 Avenue SE, Calgary, AB T2G 0V2 · Phone: (403) 288-4880 · Fax: (403) 288-4886
Email: info@mayacentre.com · Website: www.mayacentre.com

Part A continued: HISTORY

Current health conditions you desire improvement in **and** length of time they have been a concern to you, placed in order of importance:

1.
2.
3.
4.
5.
6.

To what extent do these areas interfere with your daily activities (work, sleep, etc.)?

Have you been given a diagnosis for this problem -- if so, what?

Family History

Check the box if there is a family history for the following health problems. If the health condition resulted in a family member death, please mark the third column with DC.

Allergies/Hay Fever	○		
Alcoholism	○		
Anemia	○		
Arthritis	○		
Asthma	○		
Cancer	○		
Diabetes	○		
Digestive Illness	○		
Epilepsy	○		
Glaucoma	○		
Headaches	○		
Heart Disease	○		
High Cholesterol	○		
High Blood Pressure	○		
Kidney Disease	○		
Mental Illness	○		
Obesity	○		
Stroke	○		
Syphilis	○		
Thyroid Condition	○		
Tuberculosis	○		
Other	○		

Abbreviation LEGEND

MGM: maternal grand mother
PGM: paternal grand father
MGF: maternal grand father
PGF: paternal grand father
F: father
M: mother
B: brother
S: sister
Sp: spouse
C: children
DC: deceased

Part A continued: HISTORY

Past Medical

Hospitalization (year, reason):

Surgeries (year, reason):

Serious Illnesses/injuries/accidents (year, cause/injury):

Childhood Illnesses:

Health as a child (1: poor to 10: excellent): If less than 8, explain:

Rheumatic Fever German Measles Polio Allergies Chicken Pox

Frequent Colds/Flus Mumps Ear Infection Skin Conditions (eczema,psoriasis)

Vacinations:

Type, year, adverse reactions:

Allergies: (list all known)

Allergy	Items	Reaction
Drugs		
Foods		
Other		

Pets:

What Kind	How Many

Medications:(prescription & over-the-counter)

Medications	Dose	How Long?	For What?

Part A continued: HISTORY

Supplements: (non-prescription, herbal, nutrional, any over-the-counter items)

Supplement	Dose	How Long?

Have you ever had general anesthetic? ○ Yes ○ No If yes, when? ______________________________

Antibiotic Use? ○ Yes ○ No if yes, when? ______________________________

Dental:

To the best of your knowledge please list all dental work/treatments you have undergone. Include fillings (specify type), pulled teeth, root canals, bridges, crowns, dentures, braces, retainer/splints, accidents/injuries or any other type of dental/jaw surgery.

Date	Treatment

Describe any current dental concerns or symptoms: ______________________________

____

Are you aware of any grinding of your teeth or clenching your jaw? ○ Yes ○ No

If yes, when? ○ day ○ night ○ both

Chemicals:

Please list any current or past exposures to solvents, chemicals, cleaning agents, insecticides, herbicides, pesticides, chemical/metal vapors, dry cleaning agents

Item	When	How Long?	Work or Home

Travel: (list back country & third world trips)

Item	When	Illness or trauma

Part A continued: HISTORY

Lifestyle

Enjoy Work? O Yes O No If No Why?

What have been your previous occupations?

Please indicate on the line below where you feel your current balance between work and play is:

All Work 0 - - - - -1 - - - - -2 - - - - -3 - - - - 4 - - - - -5 - - - - -6 - - - - -7 - - - - -8 - - - - - 9 - - - - 10 **All Play**

Physical Fitness

Exercise Regularily? O Yes O No Describe your program:

Hobbies

Please list your hobbies or recreational interests:

Support, Stressors & Personal Growth

Do you get along with your family? O Yes O No

Please list the stressors that affect you the most:	Please list the people/areas that support you the most:
1.	1.
2.	2.
3.	3.

Do you currently follow a (religious/spiritual) belief system?

Do you feel supported and comfortable with this belief system?

Do you: O Meditate O Pray O Use Visualization O Use Relaxation Techniques

O Use other Techniques? Describe:

How might you finish this statement in regards to suggestions/programs for your health......I:

O can follow the plans/programs O start programs then let things slide

O prefer choosing from options O am easily overwhelmed

How will you know when you are feeling better:

How might things look for you when your life is very good?

Do you have any concerns or reservations in pursuing complementary & alternative therapies?

Part A continued: HISTORY

Smoking:

	How Often	How Long?	Quit - When
Cigarettes			
Cigars			
Pipe			
Marijuana			

Drinking:

	How Often	How Long?	Quit - When
Liquor			
Beer			
Wine			
Coffee			
Soft Drinks			

Diet: (for each 'yes' list type, serving size & frequency)

	Yes	No	
Vegetarian	○	○	If yes, what kind? ○ Lacto ○ Ovo ○ Lacto-Ovo ○ Pesco ○ Vegan
Meat	○	○	
Fish	○	○	
Fowl	○	○	
Dairy	○	○	
Eggs	○	○	
Beans/Legumes	○	○	
Fruits	○	○	
Vegetables	○	○	
Grains/Bread/Pasta/Cereal	○	○	

Meal	Time	Food/Drink
Breakfast		
Lunch		
Dinner		
Snacks/Dessert		
Drinks	N/A	
Cravings	N/A	
Aversions	N/A	

What kind of water do you drink and how much?

Please mention any foods or drinks that aggravate your symptoms or that you find hard to digest:

Part A continued: HISTORY

Diet Continued:

How long have you been following this diet?

Do you eat or use any of the following:

- ○ Margerine
- ○ Processed/Deli Meats
- ○ Alumninum Pots/Utensils
- ○ Lard
- ○ Sugar
- ○ Microwave
- ○ Crystal/Packaged Drinks
- ○ Candy
- ○ Shortening
- ○ Artificial Sweeteners
- ○ Fried Foods

Part B - Review of Symptoms

Please complete the following section as thoroughly as you can. For every question that you answer "yes" or " past", please explain your answer further on the accompanying line.

General:

Weight	
Weight 1 Year Ago	
Maximum Weight	
When	
Height	
Date of Last Physical	
Date of Last Blood Work	

Energy: 1 (poor) - 10 (great): _______________ Does your energy vary within a day? ○ Yes ○ No

If Yes, circle & label the time(s) of day you feel is/are best (B) or (W) for you:

Midnight 1 2 3 4 5 6 7 8 9 10 11 noon 1 2 3 4 5 6 7 8 9 10 11 Midnight

What makes your energy better?

What makes your energy worse?

Sleep:

	Yes	No	Explanation
Sleep Well?	○	○	If No please specify
Insomnia	○	○	
Sleepy during the day?	○	○	
Wake up at night?	○	○	
Wake early in the morning?	○	○	
Restless?	○	○	
Nightmares/Dreams	○	○	
Wake to use washroom?	○	○	
Wake Rested?	○	○	If No please specify:
Grains/Bread/Pasta/Cereal	○	○	
Average Hours of Sleep per night			

PartB continued: REVIEW OF SYMPTOMS

Sweating:

	Yes	No	Past	Explanation
Night Sweats	○	○	○	
Perspire Profusely	○	○	○	
Perspire very little	○	○	○	
Do not perspire	○	○	○	
Sweat with high fever	○	○	○	

Skin:

	Yes	No	Past	Explanation
Eczema	○	○	○	
Psoriasis	○	○	○	
Rashes	○	○	○	
Hives	○	○	○	
Inflamation	○	○	○	
Infection	○	○	○	
Growths	○	○	○	
Changes in hair	○	○	○	
Change in nails	○	○	○	

Head:

	Yes	No	Past	Explanation
Headache	○	○	○	If yes or past please explain below:

Is the pain... ○ Heavy ○ Distending ○ Prickling ○ Burning ○ Other:

Where does it occur? ○ Forehead ○ Temples ○ Back of Head ○ Top of Head ○ Eyes ○ Behind Eyes

	Yes	No	Past	Explanation
Head Injury	○	○	○	
Dizziness or Vertigo	○	○	○	
Dandruff	○	○	○	
Dry Scalp	○	○	○	
Swollen Glands	○	○	○	
Pain or Stiffness	○	○	○	

Eyes:

	Yes	No	Past	Explanation
Glasses/Contacts	○	○	○	
Impaired Vision	○	○	○	
Eye Pain	○	○	○	
Tearing or or Dryness	○	○	○	
Red, Itching, Painful	○	○	○	
Double Vision	○	○	○	
Change in nails	○	○	○	

PartB continued: REVIEW OF SYMPTOMS

Ears:

	Yes	No	Past	Explanation
Hearing Loss	○	○	○	
Impaired Hearing	○	○	○	
Ringing	○	○	○	
Earache/Itch	○	○	○	

Nose & Sinuses:

	Yes	No	Past	Explanation
Frequent Colds/Year	○	○	○	
Nose Bleeds	○	○	○	
Stuffiness	○	○	○	
Sinus Problems	○	○	○	
Post Nasal Drip	○	○	○	

Mouth & Throat:

	Yes	No	Past	Explanation
Frequent Sore Throats	○	○	○	
Sore Tongue	○	○	○	
Sores in Mouth/On Lips	○	○	○	
Gum Problems/Bleeding	○	○	○	
Hoarseness	○	○	○	
Jaw Pain	○	○	○	
Dental Problems	○	○	○	

Respiratory/Chest:

	Yes	No	Past	Explanation
Cough	○	○	○	If Yes or Past: ○ dry ○ little phlegm ○ much phlegm
Wheezing	○	○	○	
Spitting up Blood	○	○	○	
Difficulty Breathing	○	○	○	
Pain on Breathing	○	○	○	
Shortness of Breath	○	○	○	
Shortness on Lying Down	○	○	○	
Shortness at Night	○	○	○	
Positive Tuberculosis Test	○	○	○	
Asthma	○	○	○	
Hay Fever	○	○	○	
Pain	○	○	○	If Yes or Past please describe: ○ sides ○ central chest ○ burning ○ prickling ○ distending ○ dull ○ other:

PartB continued: REVIEW OF SYMPTOMS

Heart:

	Yes	No	Past	Explanation
Chest Pain	O	O	O	If yes or past please describe below:
Is the pain... O burning O prickling O fullness O tightness O Distending O Dull O Other:				
Heart Disease	O	O	O	
High Blood Pressure	O	O	O	
Rheumatic Fever	O	O	O	
Swelling in Legs/Ankles	O	O	O	
Palpitation/Fluttering	O	O	O	

Digestion/Abdomen:

	Yes	No	Past	Explanation
Stomach/Abdominal Pain	O	O	O	If yes or past please describe below:
Is the pain... O cramping O prickling O fullness O Distending O Dull O Other: ____				
Pain is relieved by: O pressure O hot O cold O bowel movement				
Trouble Swallowing	O	O	O	
Heartburn	O	O	O	
Change in Thirst	O	O	O	
Do you prefer	O hot	O cold	O not thirsty	
Change in appetite	O	O	O	If yes or past please describe below:
Describe the change as...	O abnormal O overeating O under eating O hungry yet cannot eat			
Taste/Feeling in Mouth	O bland O sour O salty O hot O sweet O bitter O sticky O metallic			
Nausea	O	O	O	
Vomiting	O	O	O	
Belching/gas/bloating	O	O	O	
Do these symptoms occur...	O during meals O 1 hour after meals O 2-3 hours after meals			
Heaviness from foods	O	O	O	
Liver/gall bladder disease	O	O	O	
Gall stones	O	O	O	
High Cholesterol	O	O	O	
Diabetes	O	O	O	
Mononucleosis	O	O	O	
Ulcers	O	O	O	
Pain before eating	O	O	O	
Pain after eating	O	O	O	
Low Blood Sugar/Hypoglycemia	O	O	O	
Irritable before meals	O	O	O	
Tired after eating	O	O	O	
Distress from fats/greasy foods (nausea, dizziness, headaches)	O	O	O	

PartB continued: REVIEW OF SYMPTOMS

Digestion/Abdomen Continued...

Rapid Weight Change	○	○	○	
Hiccups	○	○	○	

Bowel Function:

Frequency of Bowel Movements	# times per ○ day ○ week			
Usual time of Bowel Movements				
Consistency of Bowel Movements				
	Yes	No	Past	Explanation
Diarrhea	○	○	○	
Constipation	○	○	○	
Alternate diarrhea & constipation	○	○	○	
Loose/Broken Stools	○	○	○	
Stool Hard to Pass	○	○	○	
Blood/Mucus in stools	○	○	○	
Undigested Food in Stool	○	○	○	

Urinary:

	Yes	No	Past	Explanation
Pain on Urination	○	○	○	
Burning on Urination	○	○	○	
Increase in Frequency	○	○	○	
Frequency at Night	○	○	○	
Change in Colour	○	○	○	
Change in Odor	○	○	○	
Unable to Hold Urine	○	○	○	
Incomplete Urination	○	○	○	
Bladder Infections	○	○	○	
Kidney Stones	○	○	○	

Circulation:

	Yes	No	Past	Explanation
Deep Leg Pain	○	○	○	
Cold Hands/Feet	○	○	○	
Varicose Veins	○	○	○	
Hemorrhoids	○	○	○	
Anemia	○	○	○	
Easy Bleeding/Bruising	○	○	○	

PartB continued: REVIEW OF SYMPTOMS

Neurological:

	Yes	No	Past	Explanation
Fainting	○	○	○	
Seizures	○	○	○	
Paralysis	○	○	○	
Muscle Weakness	○	○	○	
Memory Loss	○	○	○	

Sexual Function:

	Yes	No	Past	Explanation
Change in Libido	○	○	○	
Loss of Libido	○	○	○	
Infertility	○	○	○	
Veneral Disease	○	○	○	

Female Reproduction:

	Yes	No	Past	Explanation
Age Menses Began				
Date of Last Menstruation				
No. of days of Menstrual Flow				
Length of Complete Cycle				
Regular Self Breast Exam	○	○	○	
Date & Results of last PAP				
Abnormal PAP's	○	○	○	
No. of Pregnancies				
No. of Live Births				
No. of Miscarriages				
No. of Abortions				
Sexually Active?	○	○	○	
Birth Control	○	○	○	
Spotting Between Periods	○	○	○	
Are cycles regular?	○	○	○	If No, please describe: ○ early ○ delayed ○ irregular
Pain During Intercourse	○	○	○	
Cramps	○	○	○	
Abnormal Vaginal Discharge	○ yellow ○ white ○ thick ○ strong odor			
Vaginal Infections	○	○	○	
Menstrual Flow	○ normal ○ heavy ○ light			
Colour of Flow	○ normal ○ bright red ○ dark red ○ light red			
Consistency of Flow	○ thick ○ thin ○ clots			
PMS	○ breast tenderness ○ moods ○ water retention ○ headaches ○ craving ○ back ache ○ acne ○ bloating ○ other: ______			
Ovarian Cysts	○	○	○	

PartB continued: REVIEW OF SYMPTOMS

Female Reproduction Continued...

Uterine Fibroids	○	○	○	
Difficulty Concieving	○	○	○	
Menopausal Symptoms	○	○	○	

Male Reproduction:

	Yes	No	Past	Explanation
Date and results of most recent rectal exam for an enlarge prosteate exam.				
Impotence	○	○	○	
Premature Ejaculation	○	○	○	
Noctural Emissions	○	○	○	
Hernias	○	○	○	
Testicular Masses	○	○	○	
Testicular Pain	○	○	○	
Are you Sexually Active?	○	○	○	
Sexual Difficulties	○	○	○	
Any prostate problems?	○	○	○	
Discharge/Sores	○	○	○	
Difficulty starting/stopping urination	○	○	○	
Birth Control	○	○	○	

Risk of Infection:

	Yes	No	Details
HIV	○	○	
Hepatitis B	○	○	
Hepatitis C	○	○	

Emotional:

	Yes	No	Past	Explanation
Mood Swings	○	○	○	
Depression	○	○	○	
Anger/Resentment	○	○	○	
Anxiety/Nervousness	○	○	○	
Fear	○	○	○	
Helpless				
Apathy				

PartB continued: REVIEW OF SYMPTOMS

Musculoskeletal:

	Yes	No	Past	Explanation
Joint Pain/Stiffness	○	○	○	
Muscle Pain/Stiffness	○	○	○	
Muscle Spasms/Cramps	○	○	○	
Low Back Pain	○	○	○	
Numbness/Tingling	○	○	○	
Arthritis	○	○	○	
Broken Bones	○	○	○	

Miscellaneous:

	Yes	No	Past	Explanation
Thyroid Problems	○	○	○	
Heat Intolerance	○	○	○	
Cold Intolerance	○	○	○	
Fever	○	○	○	
Chills	○	○	○	
Alternating Chills & Fever	○	○	○	
Body Feels Cold	○	○	○	
Easy Weight Gain	○	○	○	
Rapid Weight Change	○	○	○	
Dizzy Upon Standing/Bending	○	○	○	
Fluoride Toothpaste	○	○	○	
Drink Tap Water	○	○	○	

Part C: STRESSORS & SYMPTOMS

Using the timeline below, list the ***stressors*** (surgery, accidents/injury, change in work/residence/relationships, births, loss, mental/emotional stress etc.) and ***symptoms*** (pain, digestive concerns, fatigue, headaches, allergies, menstrual changes, behavior/mood changes, etc.)

STRESSORS:

SYMPTOMS:

Part D: NEUROTRANSMITTER QUESTIONNAIRE

In the questionnaire that follows, read each statement and score it in the margin as follows:

- 0 - points if this statement is not true at or does not apply to you.
- 1 - point if the statement is true a lot of the time and/or is affecting the quality of your life.
- Please respond to all questions as though you were not taking any medications or supplements.

SECTION 1: Type - S

#	Question	Pts
1.	Do you have a tendancy to be negative or have dark pessimistic thoughts?	
2.	Are you often worried or anxious?	
3.	Do you have feelings of low self-esteem and/or lack of confidence?	
4.	Are you self-critical and feel guilty over small issues?	
5.	Do you have obsessive, repetitive, angry, useless thoughts that you are unable to turn off? Do they happen when you are trying to fall asleep?	
6.	Can your behaviour become obsessive? This can show up as difficulty making transitions, being inflexible, a perfectionist, controling? Computer, TV or work addict?	
7.	Do you suffer from seasonal affective disorder? Tend to get blue in the winter months? Symptoms of this are a tendancy to gain weight, fatigue, depression, and sleepig problems during the winter.	
8.	Are you apt to be irritalbe, impatient, edgy or angry?	
9.	Are you shy or fearful? Can you be nervous or panicky about heights, flying, enclosed spaces, public performances, bugs, crowds, leaving house etc.?	
10.	Do you have anxiety or panic attacks?	
11.	Do you suffer from PMS or menopausal moodiness (tears, anger and/or depression)?	
12.	Do you dislike hot weather?	
13.	Do you find it hard to get to sleep?	
14.	Do you wake up at night, have restless or light sleep, or wake to early in morning?	
15.	Do you find relief from the above symptoms through exercise?	
16.	Do you crave sweet or starchy snacks, wine, or marijuana in the afternoons, evenings or in the middle of the night?	
17.	Do you or have fibromyalgia, TMJ?	
18.	Have you had suicidal thoughts or plans?	
19.	Do you have gastrointestinal disorders such as irritable bowel, gas and/or bloating?	
20.	Do you suffer from general fatigue?	
	TOTAL	

Part D: NEUROTRANSMITTER QUESTIONNAIRE

SECTION 2: Type - D

#	Question	Pts
1.	Do you feel flat and bored a lot of the time?	
2.	Do you like to sleep more than normal and are slow to get out of bed?	
3.	Do you crave or use stimulants like coffee, recreational drugs, alcohol and chocolate, diet soda, ephedra and cocaine to get high?	
4.	Do you lack libido, a reduced sex drive?	
5.	Do you feel that you have reduced feelings of satisfaction, and assertiveness.	
6.	Has your short term memory, concentration and ability to learn changed for the worse?	
7.	Do you lack appetite?	
8.	Do you tend to have muscle stiffness?	
9.	Do you crave pleasurable experiences?	
10.	Have you been under a lot of stress in your life from traumatic experiences?	
11.	Do you get more accomplished under high stress environments?	
12.	Are you a procrastinator, waiting until the last minute to accomplish tasks?	
13.	Do you tend to be low on physical or mental energy?	
14.	Do you have to push yourself to exercise?	
15.	Is your drive, enthusiasm, and motivation on the low side?	
16.	Do you have difficulty focusing and concentrating?	
17.	Are you easily chilled, cold hands and feet?	
18.	Do you tend to put on weight easily?	
19.	Do you often wish that you were more alert and motivated?	
20.	Do you often have spontaneous muscle twitches, restless leg syndrome?	
	TOTAL	

SECTION 3: Type - T

#	Question	Pts
1.	Low energy and/or lethargy.	
2.	Require lots of sleep, and have trouble getting up in the morning.	
3.	Suffer from depression this may also include post partum.	
4.	A tendency to feel cold, especially in your hands and feet.	
5.	Poor concentration, mental sluggishness, and/or poor memory.	
6.	A family history of thyroid problems?	
7.	Weight gain that began with: The onset of menstruation, after a miscarriage, abortion, birth, and/or menopause.	
8.	Chubby or overweight since childhood.	
9.	Tendency to excessive weight gain or inability to lose weight despite normal eating.	
10.	Hoarseness and/or gravelly voice.	
11.	Low blood pressure, and/or hear rate.	

Part D: NEUROTRANSMITTER QUESTIONNAIRE

SECTION 3: Type - T continued

12.	Menstrual problems, excessive bleeding, severe cramping, irregular menses, PMS, scanty flow, late or early menarchy (before 12) premenopausal cessation of menstruation.	
13.	Reduced sex drive.	
14.	Swollen eyelids and face, general water retention.	
15.	Thinning or loss of outside eyebrow hair.	
16.	Tendency to have low blood pressure.	
17.	Headaches (including migraines)	
18.	High cholesterol, atherosclerosis, and/or high homocysteine.	
19.	Lump in throat and/or trouble swallowing pills.	
20.	Slow body movement or speech.	
21.	Change in hair or skin (thinning/loss/ dryness)	
22.	Weak brittle nails	
23.	Constipation	
24.	Tight tendons, muscle stiffness/ tension.	
	TOTAL	

SECTION 4: Type - A

#	Question	Pts
1.	Do you often feel overworked, pressured or dead-lined?	
2.	Trouble relaxing, or loosening up	
3.	Body tending to be stiff, uptight, tense?	
4.	Easily upset, frustrated, or snappy under stress?	
5.	Often feel overwhelmed or as though you just cant get it all done?	
6.	Weak, shaky at times?	
7.	Sensitive to bright light, noise, or chemical fumes? Need to wear dark glasses?	
8.	Feel significantly worse if you skip meals or go too long without eating?	
9.	Use drugs or food to relax and calm down?	
10.	Have type II diabetes, hypoglycemia?	
11.	Tend to gain weight around the middle?	
12.	Do you dislike hot weather?	
13.	Reduced sex drive.	
14.	Chronically fatigued: a tiredness that is not usually relieved by sleep?	
15.	Feeling unwell a lot of the time, tend to have colds and flu's that hang on?	
16.	Decreased tolerance to cold, feeling cold a lot?	
17.	Small irregular brown spots have appeared on skin?	
18.	Hands and legs get restless-experience meaningless body movements?	
19.	Often become hungry, confused, shaky, or somewhat paralyzed under stress?	
20.	Water retention, bloating, digestive problems?	
21.	Feeling "wired" yet "tired at the same time.	
	TOTAL	